



Abilene-Taylor County Public Health District (ATCPHD)

(English)

Office use only	
<input type="checkbox"/>	Eligible
<input type="checkbox"/>	Ineligible
Why?	

Eligibility Form

Community Development Block Grant Funding:

- The ATCPHD will provide low or no-cost services for individuals residing in Abilene who meet specific eligibility criteria(s).
- Funding and/or service limitations may apply.** Applicants must provide proof of income for all income sources of anyone living in the household. Applicants must also provide social security cards for all members of the household and picture identification for anyone over the age of 18.

Patient Information

Full Name:

Last

First

M.I.

Address:

Street Address

Apartment/Unit #

City

State

ZIP Code

County

Patients must provide evidence of identification:

(Select at least one)

- | | |
|---|--|
| <input type="checkbox"/> Valid Driver's License | <input type="checkbox"/> Birth Certificate |
| <input type="checkbox"/> State Issued ID | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> Passport | <input type="checkbox"/> Other _____ |

Patients must provide evidence of residency:

(Select at least one)

- | | |
|--|---|
| <input type="checkbox"/> Utility Bill | <input type="checkbox"/> Property Tax Receipt |
| <input type="checkbox"/> Lease Agreement | <input type="checkbox"/> Written Verification from Facilities
(i.e. assisted living, group home) |
| <input type="checkbox"/> Insurance Card | |

Home Phone:

Cell Phone:

Email:

Birth Date:

(mm/dd/yyyy)

Age:

SSN or Gov't ID:

Gender: ☐ Female ☐ Male ☐ Other

Disability ☐ Yes ☐ No

Applicant's
Race/Ethnicity:

- | |
|---|
| <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Black/African American |

- | |
|---|
| <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian |

☐ Biracial (Black/African American & White)☐ Native Hawaiian/Other Pacific Islander☐ Hispanic/Latino☐ Other _____**Family member(s) (including applicant) (must provide SSC for all members of the household and ID for those over 18.)**

First Name	Last Name	Age	Social Security Card	Driver's License/ID
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Emergency Contact Information

Full Name:

*Last**First**M.I.*

Address:

*Street Address**Apartment/Unit #**City**State**ZIP Code*

Primary Phone:

Cell Phone:

Relationship:

Household Income Information (Gross Monetary Income: before taxes or deductions)Monthly
Income:

Income
Source 1:☐ Full-time job☐ Part time job☐ Self-employment☐ Unemployment☐ Social Security☐ Pension/Retirement☐ Alimony/Child
Support☐ Other _____

Patients must provide evidence of income (no older than 60 days):

☐ Pay stub☐ Copy of last year's federal tax return☐ Self-employment ledger documentation☐ Unemployment Benefits Letter☐ Wages and tax statement☐ Other documents as approved by staff☐ Social Security Benefits Letter

Household Income Information (Gross Monetary Income: **before** taxes or deductions)

Monthly
Income: _____

Income
Source 2: _____

- ☐ Full-time job
☐ Part time job
☐ Self-employment

- ☐ Unemployment
☐ Social Security
☐ Pension/Retirement

- ☐ Alimony/Child Support
☐ Other _____

Patients must provide evidence of income (no older than 60 days):

- ☐ Pay stub
☐ Copy of last year's federal tax return
☐ Self-employment ledger documentation
☐ Unemployment Benefits Letter
☐ Wages and tax statement
☐ Other documents as approved by staff
☐ Social Security Benefits Letter

No Income Statement

I, _____ verify that I (or my household) have no source of income at the time of eligibility screening for services. I understand that by signing the No Income Statement, I am attesting to the fact that I have no source of income and/or providing proof of income compromises my safety.

Notice to Individual: My signature here certifies that this information is true and correct to the best of my knowledge.

Print Patient Name

Date of Signature

Patient Signature

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- Family is:
- ☐ 30% or less (Extremely Low Income)
☐ 31%-50% (Very low income)
☐ 51%-60% (Low Income)
☐ 71-80% Moderate Income

Number in household : _____ Annual Income: _____

Applicant eligible: _____ Date: _____

Personnel Signature: _____